Billing for MSS

- **Bill MAA using the mother's Patient Identification Code (PIC) found on the DSHS Medical Identification Card.**

- MSS providers must have an individual face-to-face contact with the pregnant/post pregnancy client before billing any of the integrated MSS/ICM services in the fee schedule, **except** for the following performance measures. Neither performance measure is included in the maximum of 60 units that may be billed per maternity cycle. The performance measures are billable only if the required client information has been collected and documented in the client's medical record:
  - √ The Family Planning Performance Measure (procedure code T1023 with modifier HD); and
  - √ The Tobacco Cessation Performance Measure (procedure code S9075 with modifier HD).

- An initial face-to-face visit may be billed to MAA without a signed consent form if the client refuses further services, as long as this refusal is documented in the chart. Only services provided to the pregnant/post-pregnancy woman may be billed.

- Travel, charting, and phone calls are included in the reimbursement of each MSS procedure code.

- Community health nursing visits, nutrition visits, behavioral health visits, and community health worker visits are subject to the following ***limitations*** <u>per client</u>:

- One **unit** equals **15 minutes**

  - ✓ A minimum of 2 units must be provided per day for billed home visits;
  - ✓ A maximum of 6 units may be billed per day for any combination of disciplines in office or home visits; and
  - ✓ A maximum of 60 units from all disciplines combined may be billed for office and/or home visits over the maternity cycle (pregnancy through two months post-pregnancy).

- If the mother becomes pregnant again within 12 months from the previous pregnancy, enter the new "Due Date" in field **19** on the HCFA-1500 claim forms for new MSS services. This "resets" the claims processing clock for the new pregnancy.

Fee Schedule for Maternity Support Services

Use the most appropriate diagnosis code (such as V22.2) when billing for the following procedure codes:

Procedure Code/ Modifier	HCPCS Description	Service	July 1, 2005 Maximum Allowable	
			Office Visit	Home Visit
T1002 HD	RN services, up to 15 minutes **1 unit = 15 minutes**	MSS Community Health Nursing Visit	$25.00	$35.00
S9470 HD	Nutritional Counseling, dietician visit **1 unit = 15 minutes**	MSS Nutrition Visit	$25.00	$35.00
96152 HD	Behavioral HealthSpecialist**1 unit = 15 minutes**	Psychosocial Visit	$25.00	$35.00
T1019 HD	Personal Care Services, (Community Health Worker) **Not in a hospital 1 unit = 15 minutes**	Community Health Worker Visit	$14.00	$18.00

What services are covered under ICM?

MAA reimburses approved providers on a fee-for-service basis for case management under the ICM program including:

- Assessing risk and need;
- Reviewing and updating the infant and parent(s) service plan;
- Referring and linking the client to other agencies; and
- Advocating for the client with other agencies.

The case management activities listed above are covered under the ICM program only when:

- Documented in the client's record;
- Performed by a qualified staff person acting within his or her area of expertise; and
- Used according to program design**.**

Billing for ICM

Bill MAA for ICM services using the baby's Patient Identification Code as listed on the baby's DSHS Medical ID card. **Do not use the mother's PIC.**

ICM is considered family-based intervention. Therefore, the infant [and family] are only allowed one Title XIX Targeted Case Manager at a time.

The most common examples of duplicate services include nursing intervention services provided to families at risk for child abuse and neglect. The duplication occurs because of overlapping services delivered by various agencies.

Note: DSHS contracts with local health jurisdictions, DOH/OCSHCN, and other state agencies to provide services to specific client groups. Some Special Health Care Needs and HIV/AIDS clients receive services from more than one agency. The following are examples of agencies that provide service to DSHS; Children's Administration, Child Protective Services (CPS) and local health jurisdictions.

Travel expenses, charting time/documentation, phone calls and mileage are included in the reimbursement rate for ICM.

ICM is provided for parent/newborn meeting eligibility criteria. (Services can be provided from the end of the mother's maternity cycle to the newborn's first birthday.) The following *limitations* per client apply:

One unit equals 15 minutes

- A maximum of 6 units may be billed per month; and
- A maximum of 40 units may be billed during the 10 months following the maternity cycle.

What if the mother becomes pregnant again before ICM ends?

Enter the new "Due Date" in field **19** on the HCFA-1500 claim forms. This "resets" the claims processing clock for the new pregnancy. All future visits/billing will be for the new pregnancy using MSS procedure codes. You may no longer bill under the Infant's PIC number or for ICM codes.

How do you bill for ICM if there was a multiple birth?

ICM is billed using one of the infants' PIC numbers. ICM is a family service and must not be billed for each individual infant.

Fee Schedule for ICM

Effective for dates of service on and after July 1, 2005:

Procedure Code/ Modifier	Diagnosis Code	HCPCS Description	All Settings Maximum Allowable
T1017 HD	V20.1	Targeted Case Management, each 15 minutes 1 unit = 15 minutes	$ 20.00